Rhode Island Health Plans' Performance Report 2005

RHODE ISLAND DEPARTMENT OF HEALTH

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

April, 2007

To all Rhode Islanders:

We are pleased to present the eighth annual publication of the *Rhode Island Health Plans' Performance Report*. This Report, based on 2005 data, provides information on 29 separate measures covering 7 dimensions of performance (i.e., enrollment, utilization, prevention, screening, treatment, access, and satisfaction). Health plan performance is both trended over time and benchmarked to regional and national comparisons.

Public performance reporting is one of the most effective ways to focus healthcare improvement efforts, and a way to hold health plans accountable for the way services are provided. This information may also guide policy-makers in their efforts to create a more 'balanced' healthcare delivery system promoting prevention and primary care.

In 2005, Rhode Island (RI) health plans performed 'better' than their national counterparts on 9 of 15 clinical quality measures, and performed 'worse' on only 1 measure. For example, RI plans delivered preventive services such as adolescent immunization and smoking cessation advice to a greater percentage of their members than most other health plans nationwide. Screening rates for colorectal and breast cancers also exceeded the national rates.

However, several measures illustrate opportunities that health plans have to improve healthcare delivery in RI. For example, the rate of visits to hospital emergency departments remained higher than the U.S. rate by 6 percent. In general, the use of an emergency department for primary care suggests there are barriers to accessing primary care providers, even among people with health insurance. Other measures also demonstrate the need for enhanced primary care for detection and disease management. RI's 2005 chlamydia screening rate was only 39 percent, and its antidepressant medication management rate was only 31 percent.

The Office of the Health Insurance Commissioner and the Department of Health are together leading efforts towards creating a more 'balanced' healthcare system, one item on Governor Donald L. Carcieri's health policy agenda. We applaud RI's health plans for their ongoing commitment to quality improvement, and look forward to working with them in shaping RI's healthcare delivery system to promote cost-effective, high quality services in both hospital and primary care settings.

Sincerely,

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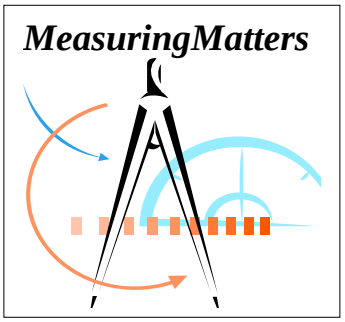
RI HEALTH PLANS' PERFORMANCE REPORT (2005)



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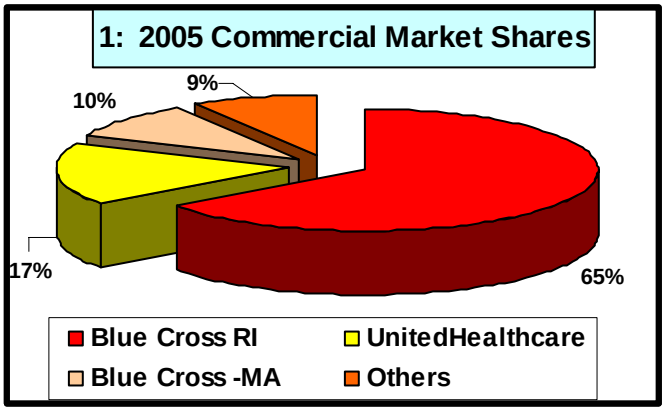
I: EXECUTIVE SUMMARY

The Health Care Accessibility and Quality Assurance Act passed by the General Assembly in 1996 instituted health plan reporting in the state. This 2005 Report is the eighth edition to present comparative commercial health plan performance information, both over time and to national and regional benchmarks.

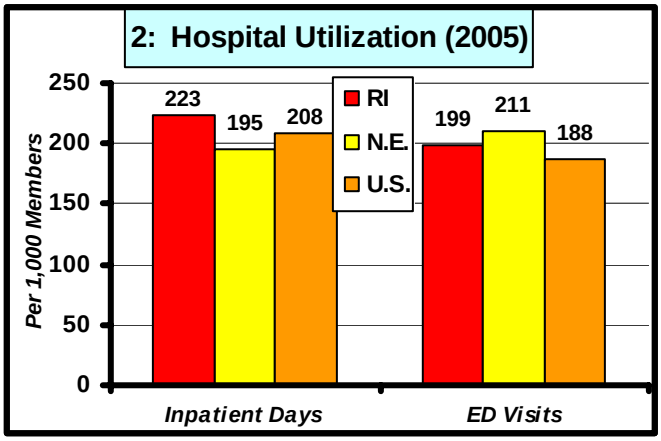
With the small number of plans in the state and the market dominance of Blue Cross & Blue Shield of RI (BCBSRI), most Rhode Islanders have limited choice of carrier. The lack of selective contracting also means that most plans deliver services through the same network of providers (i.e., the same physicians, hospitals and other suppliers participate in all plans). Therefore, the value in publishing this information is both in aiding consumer choice and in promoting accountability of the industry. Purchasers deserve to know how well the plans are performing and policy makers need empirical evidence to set effective policy. An added benefit of this effort is that performance may improve by making the results public.

Some 352,000 Rhode Islanders are commercially insured, and this Report analyzes the three largest health plans, which together cover 91% of this population. In all, 8 separate dimensions of performance are evaluated. These range from enrollment, utilization and prevention, to screening and treatment, to access, and satisfaction. A separate publication, *The Health of RI's Health Insurers (2004)*, provides a financial analysis of the state's domiciled insurers.

RI's health insurance market is concentrated in two carriers (Chart 1). BCBSRI had a market share of 65% and UnitedHealthcare of NE (UHCNE) controlled 17% of the commercial market (excluding Medicare and Medicaid). Blue Cross of MA made some inroads, but its share remained fairly modest (10%). The remainder of the market (9%) consisted of a host of smaller plans, none of which had more than 10,000 RI members.[1]



Rhode Islanders' inpatient utilization of hospital services was high when compared to regional and national rates. Inpatient days were above both the New England (N.E.) and national averages (+14% and +7%, respectively). Emergency Department utilization was –5.5% below the N.E. rate but +6% greater than the U.S. rate (Chart 2).

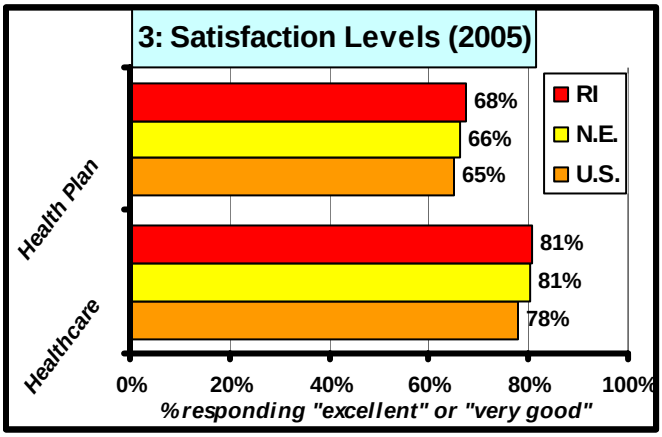


RI health plans performed fairly well in 2005 with regard to various clinical measures (Table 1). Three of these measures improved (20%), one got worse (7%), and the remainder (73%) were essentially unchanged. RI performance was less favorable when compared to the regional experience. Twelve of the RI measures (80%) were equivalent to the N.E. averages, and 3 (20%) performed worse than these averages. National comparisons were more positive. In 2005, RI exceeded the U.S. averages on 9 of the measures (60%), matched the U.S. averages on 5 measures (33%), and performed worse on only 1 measure (7%).

1: 2005 Health Plan Quality Performance			
2005 RI values compared to:	2004	N.E.	U.S.
Childhood Immunization			
Adolescent Immunization	*+7%*	*-7%*	*+35%*
Advising Smokers to Quit			*+10%*
Colorectal Cancer Screening			*+20%*
Breast Cancer Screening			*+6%*
Cervical Cancer Screening			
Chlamydia Screening	*+8%*		*+11%*
Diabetes -Eye Exam Screening	*+9%*		*+20%*
Diabetes -HbA1c Tested			
Diabetes -HbA1c 'Controlled'	*-7%*	*-8%*	
Beta Blocker Treatment			
Antidepressant Med. Mgmt.			*+49%*
Follow-up for Mental Illness		*-9%*	
Well Child Visits			*+28%*
Adolescent Well-Care Visits			*+54%*
+xx% 'Better'	*(<+-5%) 'Same'*	*-xx% 'Worse'*	

Clearly, this comparative analysis is positive and reflects the continued gains made by the plans in RI. However, no matter how favorable this relative performance, the absolute values on some clinical measures were lacking. For example, a RI *Chlamydia Screening* value of 39%, and an *Antidepressant Medication Management* value of 31%, both well above the national averages, underscore the need for further improvement regardless of how well RI performed on a relative basis.

Two-thirds of Rhode Islanders were satisfied with their health plans and four-fifths were satisfied with their healthcare (Chart 3), and these levels were unchanged from the previous year. RI's healthcare satisfaction level was similar to both the regional and national benchmarks. Likewise, Rhode Islander's satisfaction with their health plans was also similar to the regional and national benchmarks. Interestingly, regardless of location throughout the country, more members expressed satisfaction with their healthcare services than with their health plans.



The real utility in these analyses is in benchmarking performance to others, and promoting quality within the industry. The maxim, *'you can't improve what you can't measure'* holds true.

II: INTRODUCTION

Increasingly, the public, purchasers, providers, and policy makers are seeking meaningful information about health plans (i.e., the commercial book-of-business for RI domiciled health insurers and insurers domiciled elsewhere with more than 10,000 fully-insured RI members[1]). This Report provides the most comprehensive public source of data on plans certified to operate in Rhode Island.

Consumers and purchasers may use this information to make informed choices among competing plans or to better understand their chosen plan. The plans themselves now have comparative statistics to identify and focus improvement efforts. Policy makers may also use these data to support their decision-making.

A. Background

Not all health plans are identical. They differ in how they keep members well and how they care for them when they are ill. They also differ in how they provide access to and deliver services. Most Rhode Islanders receive their health coverage through the three commercial health plans in this Report, so learning about how they perform is essential to determining if value is received from the premium dollars expended. Consequently, in response to this need for information, the Rhode Island General Assembly passed the Health Care Accessibility and Quality Assurance Act (RIGL 23-17.13) in 1996. One stipulation of this law was a requirement that health plans submit performance data to the Department of Health (HEALTH).

To consumers, the quality, and access to care provided by a plan may affect their health. To employers, these same issues may influence worker absenteeism, productivity and the company's personnel costs.

The *RI Health Plans' Performance Report (2005)* is the eighth annual publication of this information. For more assistance in choosing a particular commercial health plan, readers are referred to: http://hprc.ncqa.org/.

B. How to Use This Information

The Report is divided into Sections containing similar dimensions of performance. Section III examines enrollment and market share. Section IV compares utilization statistics. Section V looks at prevention measures, and Section VI gives screening information. Section VII presents treatment statistics and Section VIII shows access measures. Lastly, Section IX provides the results of member satisfaction surveys. Whenever possible, National (U.S.) and Regional (New England) averages are provided to assess the State's performance relative to our N.E. counterparts and the rest of the nation.

This Report examines commercial health plans only, it does not include Medicaid or Medicare HMO plans. Information on the financial performance of RI's health insurers is presented in the publication, *The Health of RI's Health Insurers (2004)*.

Different users will use this Report in different ways, however, the following guidelines should help improve its utility for everyone.

- **No one measure in and of itself can accurately reflect health plan performance.** Therefore, the statistics should be viewed in combination and not in isolation.
- **Readers should focus on large differences between health plans** that are less likely to be caused by random chance. When comparing statewide performance to the regional and national benchmarks, differences less than +-5% usually do not signify any meaningful difference.[2]
- **Readers should recognize there may be reasons why results vary other than differences in quality or administration.** Every plan enrolls a distinct set of members with unique demographic characteristics that could affect performance (e.g., age, health status, race/ethnicity, socioeconomic status). In addition, differences in covered benefits may also influence outcomes and should be a question consumers ask about when selecting a health plan.

- **This Report examines all types of health plans (HMOs and PPOs).** HMOs are legally defined and, generally, use restricted networks to deliver care through the member's primary care provider. In addition, they may employ a variety of managed care techniques[3] to coordinate care and control costs. Other types of plans may use these exact same techniques but are not defined the same way legally, so this distinction becomes less apparent and important.
- **This Report excludes plans with fewer than 10,000 RI members.**[1] These plans are fairly minor competitors in the RI marketplace at this time, and to reduce their reporting burden, they are exempt from filing. Also, given their smaller market shares, they do not influence providers' practices to any significant extent.
- **Comparable benchmark data** (i.e., New England and United States) are from other commercial health plans included in Quality Compass (National Committee for Quality Assurance). In the Tables, the benchmarks are averages and the RI value is a weighed average based on RI enrollment of the three health plans data. In the text, reference may also be made to U.S. percentiles as a basis for comparison (e.g., a 75th U.S. percentile value of 8.5 means that 75% of all plans across the country had values below 8.5, and 25% had values above 8.5).

III: ENROLLMENT

This Section compares health plan membership information and market shares. Included is the fully-insured commercial book-of-business only,[4] and not any self-insured members for which the plans provide Third Party Administrators' services.

A. RI Enrollment is the computed RI resident enrollment in a health plan for the full year. Increasing enrollment over time is important both in terms of achieving economies of scale and increasing market share.

2. RI Commercial Enrollment[1]

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	256,446	247,543	228,824	*-8%*
UHCNE *(United)*	71,277	70,232	59,140	*-16%*
Blue Cross -MA	28,657	32,408	33,557	*4%*
Other Plans[2]	46,343	29,412	30,969	*5%*
Rhode Island	402,723	379,595	352,490	*-7%*

[1] Fully-insured commercial business only (RI-MM/12)
[2] Other Commercial Plans with <10,000 RI members & including UnitedHealthcare Insurance Company

BCBSRI remained, by far, the largest commercial insurers with 229,000 fully-insured RI members, and UHCNE followed with 59,000 RI members. Blue Cross –MA reported the only gain in membership (+4%), to 34,000 Rhode Islanders. Total RI commercial enrollment fell every year reflecting the general decline in insurance coverage and the switch to self-insurance by some larger companies.

B. RI Market Shares calculates each plan's percentage of the total RI fully-insured enrollment. In many respects, market share is more important than simple enrollment (although the two are related). It is possible in a shrinking market for a plan's enrollment to decline while its market share increases. Market share, to a large extent, determines how aggressively a plan can negotiate provider contracts, rates and commissions, to enhance its competitive position.

3. RI Commercial Market Shares

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	63.7%	65.2%	64.9%	*0%*
UHCNE *(United)*	17.7%	18.5%	16.8%	*-9%*
Blue Cross -MA	7.1%	8.5%	9.5%	*12%*
Other Plans	11.5%	7.7%	8.8%	*13%*
Rhode Island	100%	100%	100%	---

BCBSRI controlled 65% of the commercial market in 2005, followed by UHCNE with a 17% share. Blue Cross –MA posted the only gain in market share (+12%), to 10% in 2005.

IV: UTILIZATION

This Section gives information[5] on the services utilized by members in a health plan.

A. Hospital Discharges are the average number of acute-care hospital discharges (excluding substance abuse, mental health and newborn discharges) used per 1,000 members in a plan.

4. Hospital Discharges *(per 1,000 members)*

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	56.7	58.6	56.8	*-3%*
UHCNE *(United)*	53.2	67.4	65.0	*-4%*
Blue Cross -MA	49.6	51.9	51.9	*0%*
Rhode Island	55.4	59.7	57.8	*-3%*
New England	51.4	52.0	51.7	*-1%*
United States	58.2	58.6	57.4	*-2%*

RI's hospital discharge rate decreased slightly in 2005 and ended the period comparable to the U.S. rate. However, in 2005, RI remained +12% above the N.E. rate, although that gap narrowed slightly (+15% higher in 2004).

B. Hospital Days are the average number of acute-care hospital days used by every 1,000 members in a plan. Excluded are substance abuse, mental health and newborn days.

5. Hospital Days *(per 1,000 members)*

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	249	249	225	*-9%*
UHCNE *(United)*	219	255	219	*-14%*
Blue Cross -MA	209	214	214	*0%*
Rhode Island	240	247	223	*-10%*
New England	198	195	195	*0%*
United States	215	214	208	*-3%*

Hospital day utilization decreased –10% in 2005, while the benchmarks remained steady. However, RI continued its historical pattern of exceeding both the regional and national use rates. In 2005 local utilization was +14% higher than the N.E. and +7% higher than the U.S. rates.

C. Average Length of Stay is the average number of inpatient days for each acute-care hospital admission.

6. Average Length of Stay

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	4.39	4.25	3.97	*-6%*
UHCNE *(United)*	3.80	3.80	3.37	*-11%*
Blue Cross -MA	4.10	4.10	4.13	*1%*
Rhode Island	4.33	4.13	3.86	*-6%*
New England	3.85	3.76	3.78	*0%*
United States	3.69	3.65	3.63	*-1%*

With the –6% drop in the 2005 statewide ALOS, RI improved its relative position to one consistent with the regional value, and +6% greater than the national value.

RI's +6% longer length of stay than the U.S. rate may be partially warranted because of the complexity of its patients. In 2005, RI's Medicare case-mix index was the third highest in the country (1.23), below only Florida, and Maryland (at 1.25 each).[6]

D. ED Visits is the number of visits to hospital emergency departments (excluding behavioral health visits and those that resulted in the patient being admitted) for every 1,000 members in a plan. Emergency departments are often used to provide primary or secondary care that could be delivered more cost-effectively and more properly elsewhere.

7. ED Visits *(per 1,000 members)*

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	197	191	196	*3%*
UHCNE *(United)*	200	207	208	*1%*
Blue Cross -MA	204	200	209	*5%*
Rhode Island	198	195	199	*2%*
New England	197	196	211	*8%*
United States	181	177	188	*6%*

RI has consistently struggled with ED utilization rates about +10% higher than the U.S. rates. However, this situation improved in 2005, with RI ending the period only +6% higher than the national rate. In addition, RI improved its performance relative to the regional experience, ending –5.5% below the N.E. rate.

E. Mental Health Utilization is the percentage of members with a mental health benefit that received any mental health treatment (i.e., inpatient, intermediate or ambulatory) during the year. Mental illness is widely under-diagnosed and a major quality-of-life determinant.

8. Mental Health Utilization *(% accessing care)*

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	9.9%	10.1%	10.4%	*3%*
UHCNE *(United)*	8.6%	9.2%	8.8%	*-4%*
Blue Cross -MA	10.4%	10.9%	11.1%	*1%*
Rhode Island	9.7%	10.0%	10.2%	*2%*
New England	7.8%	8.3%	8.9%	*8%*
United States	5.4%	5.5%	5.6%	*1%*

Relative to the U.S. and N.E., RI's mental health utilization continues to be a healthcare 'bright-spot', in that this statistic may also be used as a proxy for access to these services. RI's 2005 value of 10.2% continued to outpace both the regional average (+14% higher) and the national average (+81% higher). In fact, RI's 2005 value was above the 90th U.S. percentile value of 8.3%.

Without knowing the comparative mental illness incidence rates, the actual utilization of services, and outcomes, however, one cannot conclude that mental health treatment was any better in RI than elsewhere. One may only state that a greater percentage of RI members accessed these services (at least once).

F. Substance Abuse Utilization is the percentage of members filing an alcohol and other drug claim for substance abuse treatment services (i.e., inpatient, intermediate or ambulatory) during the year. Substance abuse is very expensive in terms of personal and societal costs. Treatment, even considering recidivism rates, remains the most cost-effective response to this disease.

9. Substance Abuse Utiliz. *(% accessing care)*

	2003[1]	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	---	1.01%	1.02%	*1%*
UHCNE *(United)*	---	1.40%	1.29%	*-8%*
Blue Cross -MA	---	1.00%	1.07%	*7%*
Rhode Island	---	1.09%	1.07%	*-1%*
New England	---	0.84%	0.94%	*12%*
United States	---	0.73%	0.77%	*5%*

[1] ***Data were not collected***

Again, relative to the U.S. and N.E., RI's substance abuse utilization is another healthcare success story, because as with mental health, it may also be used as a proxy for access to these services. The 2005 RI experience outpaced both the regional average (+14% higher) and the national average (+39% higher). In 2005, RI's value of 1.07% fell between the 75th and 90th U.S. percentiles of 0.9% and 1.2%, respectively.

However, as with mental health, without knowing the comparative substance abuse incidence rates, the actual utilization of services, and outcomes, one cannot conclude that substance abuse treatment was any better in RI than elsewhere. One may only state that a greater percentage of RI members accessed these services (at least once).

V: PREVENTION

This Section contains measures[5] that look at how effectively a plan delivers preventive services to keep its members healthy.

A. Childhood Immunization is the percentage of children in the Plan who received the appropriate immunizations by age 2.[7] As immunizations protect children against preventable and sometimes devastating disease, they are one of the most cost-effective examples of high-quality primary care.

To enhance immunization levels in Rhode Island, HEALTH's Immunization Program[8] provides vaccines consistent with the CDC's *Recommended Childhood and Adolescent*

Immunization Schedule,[9] free of charge to pediatricians and other select providers.

10. Childhood Immunization Levels				
	2003[1]	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	---	75.5%	79.8%	*6%*
UHCNE *(United)*	---	77.6%	79.6%	*2%*
Blue Cross -MA	---	86.2%	83.5%	*-3%*
Rhode Island	---	76.9%	80.1%	*4%*
New England	---	76.1%	81.2%	*7%*
United States	---	72.5%	77.7%	*7%*

[1] ***Data were not collected***

RI's 2005 relative performance on this measure was consistent with both the regional and national averages. However, with almost 20% of RI's commercially insured children not receiving their vaccinations within the recommended timeframes, there needs to be renewed effort on the part of payors and providers to reach this population.

B. Adolescent Immunization is the percentage of adolescents (age 13) who received the appropriate immunizations.[10] Adolescent immunizations are a proven defense against common, serious and transmissible diseases such as Hepatitis B, measles, mumps and rubella.

Consistent with the previous measure, HEALTH's Immunization Program provides the appropriate adolescent vaccines free of charge to pediatricians and other select providers.

11. Adolescent Immunization Levels				
	2003[1]	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	---	63.2%	69.9%	*11%*
UHCNE *(United)*	---	74.9%	70.4%	*-6%*
Blue Cross -MA	---	84.7%	92.1%	*9%*
Rhode Island	---	67.5%	72.3%	*7%*
New England	---	68.7%	77.4%	*13%*
United States	---	46.9%	53.7%	*15%*

[1] ***Data were not collected***

RI's adolescent immunization level improved +7% in 2005, however, the regional and national averages also improved at greater rates (+13% and +15%, respectively). Nevertheless, RI finished slightly below the N.E. average (-7%), but a full +35% higher than the U.S. average. RI's 2005 value of 72.3% fell between the 75th and 90th U.S. percentiles of 68.9% and 81%, respectively.

On an individual basis, Blue Cross –MA outperformed its competitors on this measure in 2005, with an immunization level almost +31% higher than that of the next plan (UHCNE).

Similar to the childhood immunization situation, there needs to be continued progress on the part of payors and providers in getting the 37%+ of this population immunized within the recommended timeframes.

C. Advising Smokers to Quit is the percentage of members (age 18+) who are smokers or recent quitters who received advice to quit.[11] An estimated 21% of adult Americans are smokers and it is the leading preventable cause of death in the nation (~438,000 deaths per year). Seventy percent of smokers are interested in stopping, and getting advice to quit is associated with a 30% increase in the number of people who succeed.

This is a measure tracked by HEALTH's Tobacco Control Program[12] as part of its efforts to reduce smoking in the state. The Program has adopted a target level of 95% compliance on this measure.

12. Advising Smokers to Quit *(% advised)*				
	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	77.0%	80.5%	76.8%	*-5%*
UHCNE *(United)*	65.4%	83.8%	81.6%	*-3%*
Blue Cross -MA	73.1%	74.2%	79.7%	*7%*
Rhode Island	74.4%	80.6%	78.0%	*-3%*
New England	73.4%	74.4%	76.6%	*3%*
United States	68.7%	69.6%	71.2%	*2%*

RI continued to outperform the national experience, ending +10% above the U.S. average in 2005. Regionally, RI's value was equivalent to the N.E. average in 2005.

Given the marginal cost of providing healthcare advice on smoking, further gains should be made on a statewide basis when a full 22% of the affected population was not properly advised to quit.

VI: SCREENING

This Section contains information[5] on how effectively a health plan screens its members for possible medical problems. Screening is the second most cost-effective activity (behind prevention) to reduce the adverse effects of disease.

A. Colorectal Cancer Screening is the percentage of members (age 50-80) who were screened for colorectal cancer. Colorectal cancer is the second leading cause of cancer related deaths in the country (~60,000 deaths annually). Early stages of the disease are often asymptomatic so regular screening becomes the only way to detect it. In addition, colorectal screening can actually prevent the disease through removal of pre-malignant polyps.

13. Colorectal Cancer Screening Levels

	2003[1]	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	---	61.4%	62.3%	*1%*
UHCNE *(United)*	---	58.9%	61.1%	*4%*
Blue Cross -MA	---	63.8%	68.5%	*7%*
Rhode Island	---	61.1%	62.7%	*3%*
New England	---	61.6%	63.6%	*3%*
United States	---	49.0%	52.3%	*7%*

[1] ***Data were not collected***

RI's 2005 screening level was equivalent to the regional average and a full +20% greater than the national average. In 2005, RI's value of 62.7% fell between the 75th and 90th U.S. percentiles of 58.9% and 63.5%, respectively.

On an individual basis, Blue Cross –MA outperformed its competitors on this measure in 2005, with a screening level +10% higher than that of the next plan (BCBSRI).

B. Breast Cancer Screening is the percentage of women members (age 52-69) who had a mammogram within the last two years. Breast cancer is the second most prevalent cancer among U.S. women (~215,000 new cases per year), and mammography screening reduces mortality 30% for women 50 and older.

14. Breast Cancer Screening Levels

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	77.3%	75.2%	75.4%	*0%*
UHCNE *(United)*	78.4%	77.4%	77.0%	*-1%*
Blue Cross -MA	83.1%	83.3%	82.2%	*-1%*
Rhode Island	78.0%	76.4%	76.4%	*0%*
New England	80.9%	80.1%	79.0%	*-1%*
United States	75.3%	73.4%	72.0%	*-2%*

RI's breast cancer screening level was unchanged in 2005, and essentially equivalent to the regional average. However, RI ended the period +6% favorably above the national average.

Blue Cross –MA outperformed its competitors on this measure in 2005, with a screening level almost +7% higher than that of the next plan (UHCNE).

C. Cervical Cancer Screening is the percentage of women (21-64) who received a Pap test within three years. Cervical cancer is one of the most successfully treated cancers when diagnosed early, and screening has let to declining mortality rates over the past 30 years. Nonetheless, an estimated 10,000 new cases are diagnosed each year resulting in over 3,500 deaths nationally.

15. Cervical Cancer Screening Levels

	2003	2004	2005[1]	'04-'05 Change
BCBSRI *(Blue Cross)*	83.1%	82.7%	82.0%	*-1%*
UHCNE *(United)*	82.9%	82.5%	84.4%	*2%*
Blue Cross -MA	89.0%	87.8%	87.8%	*0%*
Rhode Island	83.6%	83.1%	83.0%	*0%*
New England	86.6%	86.0%	86.4%	*1%*
United States	81.8%	80.9%	81.8%	*1%*

[1] ***Plans had option of reporting previous year's value***

Even though the health plans had the option of reporting their 2004 values for 2005, BCBSRI and UHCNE elected to update their metrics in 2005. However even with these new data, RI's 2005 screening level remained essentially unchanged and consistent with both the N.E. and U.S. averages.

D. Chlamydia Screening is the percentage of women members (age 16-25) having a

chlamydia test during the year. Chlamydia is the most common sexually transmitted disease in the U.S. (~3 million infected annually), and a leading cause of infertility. Screening is essential because the disease is usually asymptomatic and easily treated with antibiotics.

16. Chlamydia Screening Levels

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	31.1%	34.6%	37.6%	*9%*
UHCNE *(United)*	33.7%	36.8%	39.2%	*6%*
Blue Cross -MA	39.8%	44.0%	46.7%	*6%*
Rhode Island	32.3%	35.9%	38.8%	*8%*
New England	34.7%	37.4%	39.5%	*6%*
United States	29.7%	32.2%	34.9%	*8%*

RI health plans improved their performance +8% on this measure, and the statewide statistic finished essentially equivalent to the N.E. average and +11% above the U.S. average. The low absolute values both locally and nationally, however, illustrate the need for further improvement as over 61% of the affected population in RI is not being screened.

Individually, Blue Cross –MA outperformed its competitors on this measure in 2005, with a screening level +19% higher than that of the next plan (UHCNE).

E. Diabetes Care –Eye Exam Screening is the percentage of members (age 18-75) with diabetes that received an eye exam for retinal disease. Diabetes is the leading cause of adult blindness in the US, so regular examinations are important to diagnose problems as early as possible.

This is one measure tracked by HEALTH's Diabetes Prevention and Control Program[13] as part of its efforts to reduce the incidence of and improve the quality of care for the disease. The Program has adopted a target goal of 70% for eye exam screening.

17. Diabetes -Eye Exam Screening

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	54.2%	59.2%	65.4%	*10%*
UHCNE *(United)*	58.9%	58.6%	60.8%	*4%*
Blue Cross -MA	63.5%	67.4%	74.7%	*11%*
Rhode Island	55.9%	59.9%	65.5%	*9%*
New England	59.9%	64.1%	68.0%	*6%*
United States	48.8%	51.0%	54.8%	*8%*

There was a +9% improvement in the 2005 statewide value, ending was essentially equivalent to the regional average. However, RI's screening value was +20% higher than the national average. RI's 2005 value of 65.5% fell between the 75th and 90th U.S. percentiles of 62.7% and 69.3%, respectively.

Individually, Blue Cross –MA performed better than its competitors on this measure in 2005, with a screening level +14% higher than that of the next plan (BCBSRI). Likewise, UHCNE performed worse than its competitors, with a screening level –7% below that of the next plan (BCBSRI).

F. Diabetes Care –HbA1c Testing is the percentage of diabetic members (age 18-75) who had their hemoglobin A1c tested. Diabetes is one of the most costly (~$100 billion annually), and prevalent (~17 million) diseases in the U.S. and much of the resultant disability may be prevented with early diagnosis and treatment.

This is another measure tracked by HEALTH's Diabetes Prevention and Control Program and it has adopted a target goal of 95% for HbA1c testing.

18. Diabetes -HbA1c Testing

	2003	2004	2005[1]	'04-'05 Change
BCBSRI *(Blue Cross)*	86.1%	90.4%	87.5%	*-3%*
UHCNE *(United)*	86.1%	88.6%	88.3%	*0%*
Blue Cross -MA	89.5%	93.2%	93.2%	*0%*
Rhode Island	86.4%	90.3%	88.2%	*-2%*
New England	88.6%	90.5%	91.0%	*0%*
United States	84.6%	86.5%	87.5%	*1%*

[1] ***Plans had option of reporting previous year's value***

Even though the health plans had the option of reporting their 2004 values for 2005, BCBSRI

and UHCNE elected to update their measures in 2005. However even with these new data, RI's 2005 screening rate remained essentially unchanged, and consistent with the N.E. and U.S. averages.

Once again, Blue Cross –MA outperformed its competitors on this measure in 2005, with a testing level almost +6% higher than that of the next plan (UHCNE).

VII: TREATMENT

This Section contains measures[5] that look at the clinical quality of care provided within a health plan, how well it treats its members who are ill and whether that care is effectively managing the disease.

A. Diabetes Care –HbA1c 'Controlled' is the percentage of diabetic members (age 18-75) whose blood sugar was under control (i.e., <9.0%). Diabetes affects ~17 million Americans and causes 20% of all deaths in adults over 25. In addition, its complications (amputations, kidney failure, blindness) may be prevented if diagnosed and addressed early.

This is a third measure tracked by HEALTH's Diabetes Prevention and Control Program, however, it has adopted an even more stringent goal of maintaining blood sugar levels under 7%.

19. Diabetes -HbA1c 'Controlled' *(<9%)*[1]

	2003	2004	2005[2]	'04-'05 Change
BCBSRI *(Blue Cross)*	64.7%	74.5%	66.3%	*-11%*
UHCNE *(United)*	60.6%	64.0%	67.2%	*5%*
Blue Cross -MA	76.2%	82.7%	82.7%	*0%*
Rhode Island	64.8%	73.2%	68.2%	*-7%*
New England	72.4%	73.9%	74.0%	*0%*
United States	68.1%	69.3%	70.3%	*1%*

[1] *This statistic is the complement of the HEDIS Diabetes Care - HbA1c NOT controlled measure*
[2] *Plans had option of reporting previous year's value*

Health plans had the option of reporting their 2004 values for 2005, however, BCBSRI and UHCNE chose to update their metrics in 2005. With these new data, RI's 2005 value decreased unfavorably (-7%), and ended the period –8% below the regional average.

Clearly this one-year negative change should be monitored and addressed to insure it does not become a long-term trend. Having almost one third of a population whose disease is not under control is not satisfactory.

On an individual basis, Blue Cross –MA again outperformed its competitors on this measure in 2005, with a value +23% higher than that of the next plan (UHCNE).

B. Beta Blocker Treatment is the percentage of members (age 35+) discharged after an acute myocardial infarction (AMI) who received an outpatient beta blocker prescription at discharge. Given the prevalence (>1 million MIs annually), and costs (~$111 billion annually) of heart disease in the U.S., beta blocker therapy has proven an effective medical treatment to reduce the risk of having another attack.

20. Beta Blocker Treatment *(after AMI)*

	2003	2004[1]	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	93.0%	93.0%	96.9%	*4%*
UHCNE *(United)*	91.7%	98.2%	98.4%	*0%*
Blue Cross -MA	96.8%	97.5%	99.5%	*2%*
Rhode Island	93.0%	94.4%	97.5%	*3%*
New England	97.2%	97.8%	98.1%	*0%*
United States	94.3%	96.2%	96.6%	*0%*

[1] *Plans had option of reporting previous year's value*

RI plans performed consistent with their regional and national peers on this measure.

C. Antidepressant Medication Management is the percentage of members (age 18+) with a new episode of depression who received medication and at least three provider contacts within 12 weeks. Almost 19 million Americans suffer from a depressive disorder annually, and depression is a major quality of life factor, with huge societal costs in terms of absenteeism and productivity.

21. Antidepres. Med. Mgmt. *(optimal contacts)*	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	28.6%	29.3%	31.1%	*6%*
UHCNE *(United)*	27.3%	26.7%	25.3%	*-5%*
Blue Cross -MA	38.7%	38.2%	37.8%	*-1%*
Rhode Island	29.2%	29.6%	30.7%	*4%*
New England	29.4%	30.5%	29.6%	*-3%*
United States	20.3%	20.0%	20.6%	*3%*

RI's low values on this measure were matched by equally low benchmarks, so the state did relatively well at least when compared to the national average (+49% higher). RI's 2005 value of 30.7% fell between the 75th and 90th U.S. percentiles of 25.3% and 31.1%, respectively.

Regardless of how well RI plans compared to the national average, almost 7 of every 10 patients are not receiving the recommended treatment, which is not favorable.

Individually, Blue Cross –MA performed better than its competitors on this measure in 2005, with a value almost +22% higher than that of the next plan (BCBSRI). Likewise, UHCNE performed worse than its competitors, with a screening level over –18% below that of the next plan (BCBSRI).

VIII: ACCESS

The metrics[5] in this Section examine if members are obtaining needed services from the healthcare system. Access is one of the most difficult concepts to measure. It is more than simply making healthcare services available. Access means the right patients get the right care in the right amounts at the right time. Most of these measures are proxies for gauging access to particular services.

A. Follow-up for Mental Illness measures the percentage of members (age 6+) who were discharged from hospitals for treatment and received a follow-up visit within 30 days. Mental disorders affect ~57 million adult Americans and are a leading factor in suicides in the U.S. Follow-up to hospitalization for mental illness is important to transitioning the patient out of the inpatient setting and for evaluating medications.

22. Follow-up for Mental Illness *(w/in 30 days)*	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	77.8%	77.2%	73.4%	*-5%*
UHCNE *(United)*	73.7%	81.8%	81.4%	*0%*
Blue Cross -MA	83.5%	84.3%	85.5%	*1%*
Rhode Island	77.5%	78.8%	76.1%	*-3%*
New England	82.5%	82.7%	83.4%	*1%*
United States	74.4%	76.0%	75.9%	*0%*

RI plans' performance was consistent with the national average in 2005, but –9% lower than the regional average.

Individually, Blue Cross –MA again performed better than its competitors on this measure in 2005, with a value +5% higher than that of the next plan (UHCNE). Likewise, BCBSRI performed worse than its competitors, with a screening level almost –10% below that of the next plan (UHCNE).

B. Well Child Visits measures the percentage of members (age 3-6) who received a primary care visit during the year. Well child visits are critical in detecting vision, speech and language problems early to help each child reach his or her full potential.

23. Well Child Visits *(3rd-6th yrs.)*	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	78.4%	81.8%	82.8%	*1%*
UHCNE *(United)*	82.0%	82.3%	82.8%	*1%*
Blue Cross -MA	89.5%	95.9%	92.4%	*-4%*
Rhode Island	80.0%	83.2%	83.8%	*1%*
New England	81.6%	83.0%	83.2%	*0%*
United States	62.7%	64.4%	65.6%	*2%*

RI's 2005 value was equivalent to the regional average, but considerably higher than the national average (+28% higher). That year, RI's value exceeded the 90th U.S. percentile value of 83.2%.

Blue Cross –MA again outperformed its competitors on this measure in 2005, with a value almost +12% higher than that of both BCBSRI and UHCNE.

C. Adolescent Well-Care Visits measures the percentage of members (age 12-21) who received a well-care visit during the year. Well-care visits are key to addressing the physical, emotional and social aspects of development in this population transitioning from childhood to adulthood.

24. Adolescent Well-Care Visits *(12 - 21 yrs.)*

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	58.8%	60.6%	58.5%	*-3%*
UHCNE *(United)*	56.3%	56.0%	57.4%	*3%*
Blue Cross -MA	69.2%	72.6%	71.9%	*-1%*
Rhode Island	59.1%	60.8%	59.7%	*-2%*
New England	54.7%	57.1%	57.8%	*1%*
United States	37.1%	38.2%	38.7%	*1%*

Similar to the *Well Child Visits*, RI's 2005 value on this measure was equivalent to the regional average, but considerably higher than the national average (+54% higher). That year, RI's value exceeded the 90th U.S. percentile of 55%. However, the fact remains that 2 of every 5 adolescents in this population are still not accessing these services.

Blue Cross –MA again outperformed its competitors on this measure in 2005, with a value +25% higher than that of the next plan (BCBSRI).

IX: SATISFACTION

This Section provides information[11] on the percentage of members who were satisfied with their experience of care, as well as complaint rates.

A. Satisfaction with Healthcare is the percentage of members rating the healthcare services received in the past year as "excellent" or "very good." Perception is an important aspect of quality in that members must believe they are receiving quality services for them to be effectively provided.

25. Healthcare Satisfaction Levels

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	82.8%	82.1%	81.1%	*-1%*
UHCNE *(United)*	80.6%	74.5%	78.7%	*6%*
Blue Cross -MA	79.9%	81.6%	80.4%	*-1%*
Rhode Island	82.1%	80.5%	80.6%	*0%*
New England	79.6%	80.9%	80.5%	*0%*
United States	76.3%	77.6%	78.0%	*0%*

This is a significant satisfaction measure in that it provides a composite score of overall satisfaction with all of the healthcare services a member receives. In 2005, the statewide healthcare satisfaction level was essentially equivalent to both the regional and national averages.

B. Satisfaction with Health Plans is the percentage of members rating the health plan as "excellent" or "very good." This and the previous measure may be used as marketing and improvement tools indicating how the so-called 'customers' view the 'product'.

26. Health Plan Satisfaction Levels

	2003	2004	2005	'04-'05 Change
BCBSRI *(Blue Cross)*	67.7%	69.0%	70.0%	*1%*
UHCNE *(United)*	57.8%	55.4%	53.9%	*-3%*
Blue Cross -MA	71.6%	74.0%	75.7%	*2%*
Rhode Island	66.0%	66.8%	67.6%	*1%*
New England	63.5%	65.8%	66.3%	*1%*
United States	61.8%	64.1%	65.2%	*2%*

This is another composite measure examining how members viewed the health plan. In 2005, the statewide health plan satisfaction level was similar to both the N.E. and U.S. averages. Interestingly, throughout the 2003-2005 period and regardless of location, members were more satisfied with their healthcare than they were with their health plans.

Individually, Blue Cross –MA again performed better than its competitors on this measure in 2005, with a value +8% higher than that of the next plan (BCBSRI). Likewise, UHCNE performed worse than its competitors, with a satisfaction level –23% below that of the next plan (BCBSRI).

C. Complaints are the percentages of members responding that they have called or written to their health plans with a complaint or problem within the past 12 months.

27. Complaint Levels

	2003	2004	2005	*'04-'05 Change*
BCBSRI ***(Blue Cross)***	12.8%	11.3%	9.8%	***-13%***
UHCNE ***(United)***	12.5%	15.2%	16.1%	***6%***
Blue Cross -MA	13.8%	10.9%	6.0%	***-45%***
Rhode Island	12.8%	12.1%	10.6%	***-12%***
New England	13.8%	13.2%	11.2%	***-15%***
United States	14.6%	13.7%	12.5%	***-8%***

RI complaint levels have historically beaten the N.E. and U.S. comparables, and the 2005 value was –6% less than the regional and –15% less than the national averages, respectively.

Once again, Blue Cross –MA outperformed its competitors on this measure in 2005, with a value -39% lower than that of the next plan (BCBSRI). Likewise, UHCNE performed worse than its competitors, with a value almost +64% higher than that of the next plan (BCBSRI).

Complaints and satisfaction are often correlated. This appears to be the case here with UHCNE having both lower satisfaction and higher complaints in 2005, than its competitors and the regional and national averages.

Endnotes:

[1] *With the exception of United Healthcare Insurance Company (UHIC), a Connecticut domiciled insurer and 'sister' corporation to UnitedHealthcare of NE (UHCNE). UHIC had 11,652 RI members in 2005, however, it was granted a waiver from reporting separate HEDIS and CAHPS measures for 2005 from HEALTH's Office of Managed Care Regulation. For the purposes of determining which health plans must file, self-insured Rhode Islanders with a health plan as the third-party-administrator (TPA) are not included, only the fully-insured Rhode Islander members.*

[2] *Confidence intervals could not be calculated for BCBSRI's clinical and access metrics because they are a composite of the HEDIS and CAHPS values for its commercial PPO and HMO products (see endnotes [5] and [11]), so differences (between health plans and between the statewide RI values and the U.S. and N.E. benchmarks) that are less than +-5% are considered to be too small to be relevant*

[3] *e.g., 'gatekeepers', second opinions, formularies, restricted networks, etc.*

[4] *Underwriting healthcare coverage is the primary function of health plans and the Statutory regulatory filings, the source for enrollment and financial data, reflect this activity only*

[5] *These values are sourced from HEDIS data. HEDIS (Health Plan Employer Data and Information Set) is a set of performance measures for the health insurance industry, administered by the National Committee for Quality Assurance (NCQA). The values reported for BCBSRI (Blue Cross –RI) are a weighted-average (based on the eligible populations) of the individual HEDIS values reported for its commercial PPO and HMO products. For the utilization measures in Section IV, the values reported for BCBSRI (Blue Cross –RI) are a combined rate (i.e., sum of the numerators over sum of the denominators) of the individual HEDIS rates reported for its commercial PPO and HMO products.*

[6] *Almanac of Hospital Financial and Operating Indicators , 2007 Ed., Ingenix, (p 459)*

[7] *Includes: four DTaP/DT, three IPV, one MMR, three HIB, three hepatitis B, one VZV vaccination, and four pneumococcal conjugate vaccinations*

[8] *For more information contact Patricia Raymond, RN at 401-222-5921, patricia.raymond@health.ri.gov*

[9] *http://www.cdc.gov/nip/recs/child-schedule.htm.*

[10] *Includes: the second MMR, three hepatitis B, and one VZV vaccination*

[11] *These values are sourced from CAHPS data. CAHPS (Consumer Assessment of Healthcare Providers & Systems) is a set of standardized surveys administered by the NCQA. The values reported for BCBSRI (Blue Cross –RI) are a weighted-average (based on RI membership) of the individual CAHPS values reported for its commercial PPO and HMO products.*

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